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January 24, 2013

Peter V. Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Comments on Qualified Health Plan Model Contract- First Draft

Dear Mr. Lee:

The Pacific Business Group on Health (PBGH) appreciates the opportunity to comment on the initial draft of the Qualified Health Plan (QHP) Model Contract. We applaud Covered California's efforts to date to advance payment and delivery system reform through its Board Recommendation Briefs and the QHP Health Plan Solicitation. The Model Contract is a critical opportunity for the Exchange to incorporate its expectations for health plan and provider accountability and performance transparency, especially as this is the initial competitive bidding process. Pacific Business Group on Health serves as a voice for purchasers, leveraging the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents. Our organization was the last administrator of the small business purchasing pool in California, PacAdvantage, so we bring very relevant experience in plan management and quality improvement.

Working in alignment with large public and private purchasers, Covered California has a significant opportunity to address the quality and affordability gaps that exist in today's health care delivery system. Covered California can assume a leadership role in providing consumers and small businesses with meaningful information on how health plans and providers perform on measures of clinical quality and patient experience. Through its contractual requirements, Covered California can establish clear performance requirements and quality reporting that advances the system transformation envisioned through the Affordable Care Act.

We recommend that Covered California incorporate the following elements into its QHP Model Contract:

1) QHPs can support a competitive marketplace and operate in a transparent way by:
    a) Participating in collaborative measurement and reporting efforts to support the availability of consumer information, such as the California Healthcare Performance Information System (see below),
    b) Report publicly dashboard measures at multiple levels including individual physician and/or facility site and service line,
    c) Make information regarding the cost of care and potential enrollee out-of-pocket costs available to the public,
    d) Prohibit participation of providers that use contractual prohibitions on quality and cost differentiation, and consumer access to comparative performance information.

e) Align contractual performance guarantees and standards with those of large purchasers to advance clinical quality and patient experience – move beyond traditional operational and service metrics.

2) As part of the Quality Reporting System required by Section 1311 of the Affordable Care Act, Covered California should adopt a comprehensive measurement dashboard that is consistent with the National Quality Strategy, and which incorporates metrics that are outcomes-focused and patient-centered, including:
   a) Clinical outcomes,
   b) Functional status,
   c) Appropriateness,
   d) Patient experience,
   e) Care coordination and care transitions,
   f) Cost, and
   g) Resource use.

   Specifically, Covered California could advance patient safety and availability of patient-reported outcomes by requiring QHPs to implement specific provider contract terms at renewal, such as reporting: 1) patient safety data to The Leapfrog Group, 2) maternity outcomes data to the California Maternal Data Center, sponsored by the California Maternal Quality Care Collaborative (CMQCC), and 3) orthopedic joint replacement data to the California Joint Replacement Registry, developed by the California HealthCare Foundation (CHCF), the California Orthopaedic Association (COA) and PBGH. Advancing use of clinical registries also helps Covered California achieve its goal of embedding shared decision making in care processes, and assuring that the right care is delivered at the right time and place.

3) QHPs should support provider systems that provide integrated care delivery and which are at the forefront of care redesign, including providers and provider networks that:
   a) Use a patient- centered, team-based approach to care delivery and member engagement,
   b) Have a demonstrated strategy to expand primary care access through workforce development,
   c) Use qualified health professionals to deliver coordinated patient education and health maintenance support, with a track record for improving care for high-risk and vulnerable populations.
   d) Support physician and patient engagement in shared decision making,
   e) Provide patient access to their health information.

4) QHPs should have an explicit, targeted percentage of provider payments designed to advance payment reform that supports evidence-based care and rewards quality, not quantity, including:
   a) Use of risk-adjusted, episode or bundled payment,
   b) Participation in shared risk and or gainsharing arrangements,
   c) Alignment of private sector approaches with public programs, such as the CMS Hospital Value-based Purchasing (HVBP) Program
   d) Inclusion of model contract language proposed by Catalyst for Payment Reform (http://www.catalyzepaymentreform.org/uploads/CPR_Model_Health_Plan_Contract_Language_011212.docx).

To elaborate on our specific recommendation to require QHPs to participate in the California Healthcare Performance Information System (CHPI), we provide some additional background and context. For many years, PBGH has been engaged with California's largest payers to pool claims data for quality measurement and reporting. As one of six original CMS Better Quality Information pilot sites, PBGH successfully operated a program to integrate commercial PPO data with Medicare Fee-for-Service claims. CHPI represents the next stage in developing a statewide all payer claims database by becoming a CMS Qualified Entity to integrate Medicare FFS data with commercial claims information on an ongoing basis. QHP participation in this effort to develop a common statewide repository of claims data can support a variety of Covered California's operational needs and program goals:

- Improve the availability and quality of information available for consumer decision support in choice of health plan, providers, and treatment;
- Support data needs for required risk assessment and risk adjustment processes (Massachusetts is adopting a similar model);
- Facilitate Covered California-specific quality measurement and reporting by potentially integrating claims data from public and private payers, which can address measurement gaps in a population that expected to have high turnover across programs due to income fluctuation and access to federal subsidies;
- Support QHP efforts to better understand and address provider performance variation, including identification of opportunities to reduce disparities in care;
- Foster integration of diverse plan and provider claims information to support broad population health improvement efforts such as Let's Get Healthy California;
- Engage in multi-stakeholder efforts to advance delivery system reform; and
- Leverage existing infrastructure to achieve economies of scale that support Covered California's measurement, accountability and transparency goals;

We appreciate the opportunity to provide these comments. We also include as an attachment our recent response to the CMS RFI on Health Plan Quality Management in Affordable Insurance Exchanges Please do not hesitate to contact me if you have any questions or would like to discuss further.

Sincerely,

David Lansky, PhD
President & Chief Executive Officer

Attachment: PBGH Response to CMS RFI Regarding Health Plan Quality Management in Affordable Insurance Exchanges

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January 17, 2013

Rebecca Zimmermann
Centers for Medicare &Medicaid Services
Department of Health and Human Services

RE: CMS-9962-NC: RFI Regarding Health Plan Quality Management in Affordable Insurance Exchanges

Dear Ms. Zimmermann:

The Pacific Business Group on Health (PBGH) appreciates the opportunity to respond to this Request for Information on the ways in which Exchanges can most effectively contribute to improving the quality of care delivered in our health care system, in part by engaging consumers and purchasers to make choices based on quality and value when selecting Exchange Qualified Health Plans (QHPs). PBGH serves as a voice for purchasers, leveraging the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents. Our organization was the last administrator of the small business purchasing pool in California, PacAdvantage, so we bring very relevant experience in plan quality management.

As some of the largest purchasers in their communities, Exchanges have a significant opportunity to address the quality and affordability gaps that exist in today's health care delivery system -- they can provide consumers and employers with meaningful information on how health plans and providers perform on measures of clinical quality and patient experience. Many consumers are not aware of the variations in quality of care and value and how these significant variations affect care delivery and outcomes. In the absence of such information, consumers rely simply on cost comparisons to make their health plan decisions. By providing clear information on the importance of quality to both the individual's care and to the system, exchanges can play a role in improving quality and reducing costs across the board, contributing to the overall system transformation that the Affordable Care Act and other programs and initiatives were designed to achieve.

Our responses to the questions below reflect our belief that there is an urgent need for exchanges to be designed to meet the needs of their beneficiaries including providing useful information on quality, access, and affordability, as well as easy-to-use decision support tools.

1. **What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?**

   Issuers play a key role in driving quality improvement via the following strategies:

   - Helping consumers to choose high value services and providers
   - Encouraging consumers to improve their own health
   - Promoting care coordination and medical homes
   - Improving management of chronic diseases
   - Targeting interventions for at-risk, populations or high-impact conditions
   - Spreading innovations in care delivery that improve access, minimize cost and maximize quality

   To promote value-based decision-making, many issuers collect information on the price and quality of services and present that information to consumers when they are making choices at the point of plan enrollment and provider selection as well as at the point of care. This drives demand towards the highest value providers and services, raising the bar for all.

   Plans also leverage financial incentives and benefit design to promote better care, including:
   - quality bonuses for providers (either retrospective or prospective as part of the contracting process);
   - putting provider compensation at risk for performance on quality and total cost measures;
   - providing grants for quality improvement activities;
   - establishing variable cost sharing or "tiering" for patients;
   - bundling payment for a set of services coordinated across providers; and
   - providing incentives for enrolling in a wellness program or improving health

   In addition to public reporting of performance, we believe that it is important for consumers to have access to information on whether, and if so, which, of these additional strategies listed above are in use by qualified health plans. This will also be important for evaluation purposes – to identify successful plan practices to improve the health of their population and the affordability of their product.

2. **What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?**

   The biggest challenge facing purchasers in tracking quality is the lack of a consistent measure set used across programs that provides meaningful information about the quality of providers and the effectiveness of services and improvement initiatives. This limits the ability to compare based on value and increases the inefficiency of data capture and reporting - consumers and purchasers are left with a multitude of measures but no summary indicator of product value upon which to make decisions.

The lack of outcome measures is a serious obstacle for evaluating health plan and provider performance. Process measures clog many performance measurement programs, most of which do not provide meaningful information. The lack of interoperable health information technology makes it difficult, at the very least, to develop measures that collect data from different settings (e.g. hospital, ambulatory, lab, pharmacy, home health) in an effort to provide a comprehensive picture of patient's health and wellness. There is also a severe lack of publicly reported measures using registry-based data that would provide the field with information on change in quality improvement over time.

On top of these challenges is the significant time lag between when the data is collected and when it is made available for accountability purposes, making it difficult to improve systems (e.g. readmissions information available in 2012 is using 2010 data). Furthermore, physician-level data and measures of teams are still mostly unavailable to consumers to use.

CMS could help address these challenges by (1) identifying a consistent set of meaningful quality measures that align with the National Quality Strategy to be implemented across public and private purchasers and payers and (2) strengthening requirements for the electronic collection, analysis and reporting of data.

Another measurement challenge relates to the nature of the Exchange population and the fact that they will churn between different programs and plans over time, limiting the ability to continuously measure their experience or improvement. Therefore, we specifically suggest that six month eligibility should be used for HEDIS/CAHPS measure calculation rather than the current year eligibility cut-off. This will help ensure that we capture the experience of the largest number of patients and do not exclude feedback from vulnerable populations.

3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.

- Consumers' CHECKBOOK/The Center for the Study of Services created the State Exchange Health Plan Comparison Tool which is modeled after the web portal currently used in the Federal Employees' Benefits Health Program (FEHBP). This tool allows consumers to view, easily and quickly, information on cost and patient experience quality data on a number of different health plans. The tool also lets consumers select health plans based on whether or not their providers are in the health plan's network, and allows the user to drill down for more granular information on how patients with various chronic conditions rated the plans.
- Louisiana provides Coordinated Care Network customers with useful information that is designed in such a way as to prevent customers from becoming overwhelmed. The CCN provides access to enrollment assistors who provide unbiased interpretations of network options.
- Minnesota's Web portal allows consumers to compare provider reimbursement rates. The portal lists the average amount health plans pay to 110 Minnesota health care providers for 103 common medical procedures.
- In Wisconsin, BadgerCare created an easy to use, consumer-friendly web site that includes a report card on plan performance; developed a streamlined health plan selection and enrollment

process; and used brokers, community partners, and other navigators to assist consumers in making informed decisions by providing information on eligibility for programs and subsidies.

- Colorado Business Group on Health is working with Bridges to Excellence to publicly report individual physicians, as well as purchasers and plans that have BTE distinction in cardiovascular care and diabetes care: http://www.coloradohealthonline.org/cbgh/index.cfm/programs/bte/
- The New Jersey Health Care Quality Institute produced a surgery safety report: http://www.njhcqi.org/njhcqinews.php?mode=view&id=630&type=3 and a hospital price transparency report: http://www.njhcqi.org/njhcqinews.php?mode=view&id=311&type=3
- Niagara Health Quality Coalition produces a New York state hospital report card: http://www.myhealthfinder.com/newyork11/index.php and physician profiles: http://www.nydoctorprofile.com/
- Oregon Health Care Quality Corporation (a recently-named QE) offers significant transparency on provider performance: http://q-corp.org/quality-reports/providers

4. What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

Exchange quality reporting is central to achieving the National Quality Strategy (NQS) priorities:

- By reporting on care safety, the Exchanges can play a role in reducing harm caused in the delivery of care. Not only would consumers have the information to choose safer providers but plans could alter their payment to reward safe care.
- By providing consumers with easy-to-interpret quality, experience and price information, they can be more engaged as partners in their care
- By reporting on quality across services and providers, consumers and employers will have better information on the most effective prevention and treatment practices for priority conditions
- Finally, by making prices more transparent and pairing them with quality data, demand will be driven to more affordable care options

To determine whether the "triple aim" is being met, Exchanges will need to promote transparency of performance on outcomes, cost and resource use, patient safety and patient experience.

5. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

CMS and Exchanges should think about quality reporting initiatives from the perspective of what information purchasers and consumers want and need, and how they use this information. Exchanges should develop their quality initiatives in concert with the development of the web portal, the navigator program, and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

Evidence indicates that consumers make decisions based on information related to choice of provider, data on patients' experiences of care and outcomes. We urge that Exchanges be required to collect and report on a comprehensive set of provider-specific measures that include data on:

- patients' experiences of care
- outcomes (including functional status, readmissions and mortality, and patient safety and healthcare-acquired conditions)
- clinical processes tightly linked to outcomes
- appropriateness of care
- cost and resource use

The measure set should evolve as more measures that resonate with those who receive and pay for care become available, including patient-reported outcome measures. Exchanges should be required to collect and report data on patients' experiences of care, and ensure patient-reported and patient-generated data measures become a core component of the Exchanges' quality initiatives, as the use of this data leads to improved outcomes. We also urge the use of measures for which public and private sector purchasers and payers are aligned in data collection and reporting, to further promote alignment across sectors. Exchanges should be empowered to add additional measures based on local, regional, and private sector innovations in quality measurement.

Wherever possible, measures should be reported at the individual-physician level. Physicians may operate as part of a team, but patients and consumers are likely to make health plan choices based on the individual physicians in the QHP's network. Having individual physician-level information "fits" with the way many consumers make health care choices. This is particularly important to the extent there are requirements to include 340B providers in issuer provider networks, as many of these providers have historically not been monitored as closely as in commercial plans. There should be well documented quality information about all providers serving Exchange enrollees. Similarly, QHPs that include patient-centered medical homes in their network should report on key outcomes – such as care coordination, chronic care clinical improvements, and patient experience – at the medical home level.

6. Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?

There are significant gaps in current clinical measure sets, most recently identified and catalogued by the Measure Applications Partnership (MAP) in its work to develop "families" of measures for patient safety, care coordination, and cardiac and diabetes care. The most glaring gaps are in the areas of patient-reported measures (including patient experience), cost and resource use, care coordination and transition measures. However, reporting on current measures will provide some level of information while the additional measures are developed.

There are additional gaps in measuring experience with the Exchange itself. In our comments to the Secretary on the development of a patient experience tool, we recommended the following four-pronged approach to collecting more complete and actionable patient experience data:

1) Establish an online service where consumers can share feedback in the form of structured responses and commentary
2) Create a plan-centric short form survey starting with select elements in the CAHPS Health Plan Survey 4.0H Adult Questionnaire

3) Create a doctor/care-centric survey that assesses patient experience with their doctor and care system
4) Create a consumer experience survey that assesses consumers' experiences with the Exchange including the eligibility, plan choice, and enrollment services

8. What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?

To evaluate the effectiveness of quality improvement strategies across plans, Exchanges will need to collect standardized information on plan activities that seek to control costs, minimize waste, ensure patient safety, close gaps in care and improve health and health care. Some of this information can be gathered through the plan accreditation process, but the assessment of quality improvement strategies is neither sufficient nor consistently captured. This is why healthcare purchasers are requiring issuers to complete the *eValue8* Health Plan Request for Information (RFI). This RFI allows Exchanges to collect data that supports reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. We recommend that CCIIO require Exchanges to capture relevant sections of eValue8 across issuers as a key part of the quality improvement evaluation strategy.

Also critical to an issuer's quality improvement strategy are the quality of its provider network and the affordability of benefits. Therefore, exchanges should collect some quality information on provider-level performance within plans as well as information on the cost of care (total cost and the member portion). Metrics should include benchmarks and performance thresholds for clinical outcomes, functional status, appropriateness, patient experience, care coordination and care transitions, and cost and resource use. Tracking these metrics over time combined with information on plan quality improvement strategies will shed light on how Exchanges are advancing affordability and quality, per the aims of the National Quality Strategy.

CCIIO should encourage quantitative reporting to indicate the scope and impact of quality improvement programs such as member engagement, the volume of providers, etc. Narrative content is prone to distortion and is not conducive to comparison across issuers, significantly limiting the utility of information.

In establishing requirements for an issuer's quality improvement strategy, Exchanges should also look to private sector purchasers to identify successful purchasing practices that should be replicated across payers. For example, Safeway instituted a reference pricing initiative and saw movement away from expensive providers without impacting outcomes[1]. CalPERS contracted with Blue Shield of California to offer a limited-network HMO and significantly decreased per member per month costs.[2] CalPERS, Pacific Gas and Electric Company, and Boeing introduced an Intensive

[1] Catalyst for Payment Reform. "Action Brief: From Reference Pricing to Value Pricing". http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf
[2] Catalyst for Payment Reform. "Action Brief: Implementing Global Payment". http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Global_Payment.pdf.

Outpatient Care Program with demonstrated success in Humboldt County[3]. Quality improvement and affordability initiatives like these that have demonstrated success in the field should be incorporated into requirements for issuer quality improvement to expand their benefit.

9. **What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?**

CCIIO should ensure its quality improvement evaluation activities align with Affordable Care Act Measurement Initiatives among other public and private sector measurement efforts to minimize reporting burden and forge a uniform path for measurement and valuation:

- Meaningful Use Incentive Program – CCIIO should take advantage of opportunities to align with incentives for "meaningful use" of interoperable platforms so that data is collected and reported electronically where appropriate
- Medicare Shared Savings Program – CCIIO should ensure performance measures accommodate new contractual structures such as Accountable Care Organizations and Patient-Centered Medical Homes so that their performance can be evaluated
- Measures Application Partnership – this group is drawing consensus around what is important to measure for the purposes of program monitoring, payment and public reporting. Exchange quality reporting requirements should draw from this effort.

CCIIO should leverage the following activities to collect and report quality improvement information:

- All-Payer Claims Databases / Medicare Qualified Entity Program – plans should be encouraged to pool information into all-payer claims databases as these entities are uniquely qualified to aggregate, analyze and report performance information in a manner that is meaningful for consumers, purchasers and providers
- eValue8 RFI – As discussed above eValue8 is a tool to collect benchmark and ongoing information on important plan quality improvement strategies in concert with accrediting bodies
- System for Electronic Rate and Form Filing (SERFF) – Since plans are already familiar with using SERFF to report information, the SERFF should be leveraged as much as possible to collect information in a uniform way and minimize reporting burden

10. **What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?**

[3] Pacific Business Group on Health. "Pacific Business Group on Health, Partners Receive $19 million Grant from Center for Medicare and Medicaid Innovation to Improve Health for 23,000 Chronically-Ill Californians". http://www.pbgh.org/storage/documents/CMMI_Grant_06.15.12.pdf.

Quality rating activities should be geared towards helping consumers understand the overall value of plans and to generate a higher value marketplace for consumers. It is critical that any measurement activity result in a summary of product value that is meaningful to consumers. Some of the priority areas for rating plan quality for consumer plan choice include:

Clinical ratings	summary ratings for preventive and chronic care
Plan service	summary rating that is a composite of ratings for customer service, cost information services and paying claims
Access to care	summary rating that is a composite of ratings for ease of getting appointments and getting needed care, tests or treatment
Doctor communications and care	includes composite ratings for doctor communications and care, patient and doctor sharing decisions, health promotion, an indicator that care is coordinated and an indicator that health care is highly rated
Provider-level quality	whether the plan provides members with hospital and physician-specific quality ratings (clarify physician-level vs. medical group, PCMH, ASO, other organizational levels)
Patient-reported information	information gleaned from the patient on outcomes (including functional status), understanding of transition instructions and self-care methods, etc.
Accreditation scores	information collected by NCQA to support accreditation

Further analysis should be completed to determine what subset of information should be displayed on exchange websites as opposed to used by Exchanges for plan management and oversight purposes.

11. What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

The Pacific Business Group on Health has published a report on "Consumer Choice of Health Plan Decision Support Rules for Health Exchanges"[4] that provides some evidence base for how quality ratings and other information should be displayed on the Exchange web portals to maximize consumer benefit. Key findings include:

- Performance results should be reported as composite, summary ratings. Single plan-level details should be available at a lower level in the information hierarchy as this information is less meaningful to consumers.
- Quality ratings should be presented in the top-most layer of plan comparison information
- Exchanges should help consumers use the quality information to make value-based decisions about their plans and providers

[4] See http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange

- Exchanges should collect and report real-time consumers ratings of plans and doctors

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market.

The California and Maryland exchanges will both be using the *eValue8* RFI as a tool to collect information on health plan quality improvement activities which is in direct alignment with purchaser activities outside the Exchange. The RFI is fielded around the country by regional employer coalitions. For example, in California, six issuers already use eValue8 under the auspices of the Pacific Business Group on Health.

15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

The health system has waited too long to take advantage of meaningful information that can guide consumer and provider decision-making. Measures have been implemented inconsistently and information provided is not actionable by consumers or purchasers to improve care. The Exchanges, as the largest purchasers in their state, have a critical role to play in accelerating the collection of standardized information to calculate health plan value. By providing clear guidance on how Exchanges should consistently implement a quality measurement framework, CCIIO will ensure information is collected in a way that is comparable and allows for value-based differentiation.

To be most effective at creating a meaningful quality measurement program, Exchanges should align their programs with existing value-based purchasing efforts in the following ways:

- Collect standardized information and make it transparent
    - Issuers should be required to complete the eValue8 Health Plan RFI to support QHP oversight and reporting of quality improvement strategies. Exchanges should use this information for plan selection, plan engagement and benchmarking.
    - Prohibit provider contracts that include transparency clauses, such as restrictions on the use of administrative data for performance reporting. Without this requirement, Exchange consumers will not have access to critical information they need to make choices about care providers and plans. These anti-transparency clauses constitute a serious weakness in the current performance infrastructure.

- Use information to improve quality and affordability of health care
    - Information should be used to help consumers identify high-value plans that meet their needs – performance information should be summarized and communicated to consumers at the time of plan choice
    - Exchanges should also leverage information for plan selection, to contract with plans that provide the highest value to consumers
    - Exchanges should also use information to identify and spread plan practices that were successful at reducing costs and maintaining quality, such as reference pricing,

revised payment models, and care models that better manage the needs of high-need populations.

- Actively support the expansion of measures to fill gaps
    - CCIIO should collaborate with ongoing public and private sector efforts to fill gaps in information on outcomes, patient experience and care coordination as well as on total cost, appropriateness of care and resource use to improve cost transparency. For example, Exchanges could test the collection and use of these measures.

We appreciate the opportunity to provide these comments. Please contact Bill Kramer, Executive Director for National Health Policy, if you have any questions.

Sincerely,

David Lansky
President & Chief Executive Officer